The Psychiatric ER Survival Guide

James Knoll, M.D.

The ER will sharpen your diagnostic and interview skills, as well as enhance your overall clinical confidence. If you follow a sound method in your approach to each patient, you will provide good care, learn a tremendous amount and avoid liability.

This guide consists of one recommended approach, but should not be considered exhaustive. Each patient must be considered on a case-by-case basis. Consultation with colleagues and/or supervisors is always recommended.

Emergency Psychiatry Training Objectives

Prioritization skills
- Most distressed, dangerous 1st
- Medical illnesses
- Emergent medication, seclusion, restraint, monitoring

Assessment & Diagnostic skills
- Rapid, focused assessment
- Mental status exam
- Risk assessment: violence, suicide
- Neuro exam as needed
- Obtaining collateral info. – records, family, outpatient treaters, etc.
- Lab work
- Diagnosis & bio-psycho-social formulation
- Accurate, timely documentation

Treatment plan
- Provide feedback, counseling, support
- Crisis intervention as needed
- Justify inpatient treatment recommendations
- Justify outpatient treatment recommendations
- Formulating risk reduction plans
- Recommend relevant community resources

Management
- Suicidal ideation
- Homicidal ideation
- Acute psychosis
- Acute intoxication or withdrawal
- Psychiatric Sx due to GMC
- Depression
- Anxiety
- Side effects of medications
- Acute bereavement
- Acute trauma
- Drug seeking
- Malingering
- Situational problems

Communications skills
- Obtaining appropriate consults
- Presenting patient history, findings and recommendations
- Completing liability-reducing documentation
- Passing on patient data to next shift
- Collaborating with other staff
- Supervising, delegating appropriately

Medico-legal skills
- Involuntary commitment laws
- Evaluating competence to give informed consent
- Public intoxication laws
- Exceptions to confidentiality
- Laws on confidentiality
- Reporting laws on: child abuse, elder abuse, DV, unsafe driving
Here are the most critical questions to ask from the get-go:

1. Is the patient acutely agitated and/or threatening?
2. Is the patient acutely suicidal and/or intent on self-harm?
3. Is this patient sick (medically), suicidal or psychotic?

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**Management of Acute Agitation/Aggression**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>Attempt to calm &amp; communicate</td>
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<tr>
<td>2.</td>
<td>Physical status?:</td>
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<tr>
<td></td>
<td>a) Take vitals</td>
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<tr>
<td></td>
<td>b) Focused physical exam</td>
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<td></td>
<td>c) Pulse oximetry</td>
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<td></td>
<td>d) Glucose finger stick</td>
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<td></td>
<td>e) Urine tox &amp; ETOH level</td>
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<tr>
<td>3.</td>
<td>If uncooperative:</td>
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<tr>
<td></td>
<td>a) Seclusion or restraints as necessary</td>
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<td></td>
<td>b) Medication options:</td>
</tr>
<tr>
<td></td>
<td>i. Oral?:</td>
</tr>
<tr>
<td></td>
<td>- Risperidone (liq. or M-tab) 2mg + Ativan 2mg</td>
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<tr>
<td></td>
<td>- Zydis 5 – 10 mg tab</td>
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<tr>
<td></td>
<td>ii. Refuses oral:</td>
</tr>
<tr>
<td></td>
<td>- 1st. Ziprasidone 20mg IM [+ ativan 2mg IM]</td>
</tr>
<tr>
<td></td>
<td>- 2nd. Haldol 5mg IM + ativan 2mg IM</td>
</tr>
<tr>
<td></td>
<td>- 3rd. Olanzapine 5 – 10 mg IM</td>
</tr>
</tbody>
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The Diagnostic “Trump Card” Method

- The following information is usually obtained and synthesized:
  - Clinical interview
  - Mental status exam
  - Records
  - Lab tests to include drug screen
  - Brain imaging, EEG (if necessary)
  - Psychological tests (if necessary)
  - Collateral data – Remember – in a psychiatric/medical emergency, confidentiality is waived!

- Certain Diagnoses “Trump” Others – always satisfy yourself that there are no Medical Conditions causing the psychiatric symptoms you are seeing.

- Once you have ruled out the “Ace” – next consider the “Joker” – substance use. One option is to proceed along this line:
  - Ace = Medical Disorder Causing Psychiatric Symptoms?
  - Joker = Substance induced Psychiatric Symptoms?
  - King = Mood Disorder with Psychosis?
  - Queen = Schizophrenia?
  - Jack = Personality Disorder?
  - Numbers cards = Others?

- There may be multiple diagnoses at the same time – however – you must attend to the most critical, life threatening ones first.

Medical Conditions (The Ace)

- Many medical conditions can produce psychiatric symptoms. Psychiatrists must always first rule out any medical causes of psychiatric symptoms – otherwise, critical medical problems will go untreated and worsen.
Medical Conditions That Commonly Produce Psychiatric Symptoms

-MEND A MIND-

Metabolic: electrolytes, TSH, Cushing’s…
Electrical: epilepsy, temporal lobe seizures…
Nutritional: thiamine/folate, anemia…
Drugs/toxins: street and/or medical drugs, lead…
Arterial: CVA, TIA
Mechanical: brain injury, Sub/epidural
Infection: HIV, Syphilis, Meningitis, Hep C
Neoplastic: primary or metastatic
Degenerative: Alz. Dz, Parkinsons, CJD, MS…

- Are there signs of Delirium, or otherwise impaired attention/concentration? - If so, immediately perform assessment of sensorium. Do not waste time collecting a history as it is likely to be fruitless. Here are the most critical and time saving exams to perform in this scenario:
  - Orientation to person, place, time and situation
  - **Digit span** (attention) – less than 5 digits forward strongly suggests a possible delirium
  - Serial subtractions, months in reverse, etc. (concentration)
  - Recall 3 words (memory)

- The validity of the cognitive MSE requires intact attentional systems! If the digit span is abnormal, all other tests will likely be abnormal.

- The patient who suddenly becomes confused and disoriented should be considered a medical emergency until proven otherwise by medical personnel.

- When a medical condition causes someone to become confused, disoriented and have a fluctuating level of consciousness, it is called Delirium. A delirium can have life-threatening consequences, and is considered a medical emergency.

- Some medications impair the body’s ability to regulate temperature. Patients who are taking certain psychiatric medications may be vulnerable to dehydration, overheating and collapse. Patients taking Lithium or antipsychotic medications are especially vulnerable to dehydration, and should not be subject to excessive heat.
• Symptoms of the deadly **Neuroleptic Malignant Syndrome** can be memorized with the mnemonic: **RAD**. It is a medical emergency with a high mortality rate.
  
  • **Rigidity** – may progress to lead pipe
  • **Autonomic instability** – heart rate and blood pressure reading abnormal
  • **Delirium** – there is often a clouding of consciousness in later stages

• Visual hallucinations occurring in persons over age 60 are suggestive of eye pathology, particularly cataracts (Beck & Harris, 1994).

• Hallucinations due to a general medical or neurological disorder can often be distinguished from schizophrenia due to the higher prevalence of prominent visual hallucinations, and the lower prevalence of thought disorder, bizarre behavior, negative symptoms, and rapid speech (Cornelius et al., 1991).

• Certain neurological syndromes can produce striking and relatively stereotyped complex visual hallucinations that often involve animals and human figures in bright colors and dramatic settings. The most common causes of complex visual hallucinations are epileptic disorders, brainstem lesions and visual pathway lesions (Manford, 1998).

**Substance Use Disorders (The Joker)**

• Persons who are intoxicated at the time of arrest and/or hospitalization are at **increased risk of suicide**.

• **Alcohol Withdrawal** - may develop hours to days after the person stops or cuts down on alcohol use. Heavy drinkers may be at risk for fatal seizures.

• Consider the possibility of: early withdrawal, Delirium Tremens and alcohol related seizures.

• Alcoholic hallucinosis typically follows the cessation or reduction of alcohol intake, and often involves quite vivid hallucinations. Auditory hallucinations are most common, but the likelihood of noise, music or unintelligible voices is greater than in schizophrenia.

• The auditory hallucinations of an alcohol-induced psychotic disorder are usually insulting, reproachful or threatening, and generally last a week or less (Sadock & Sadock, 2003).
• Visual hallucinations of small people (Lilliputian hallucinations) may be associated with alcohol use, organic disease, (Cohen, Alphonso, and Haque, 1994) or toxic psychosis (Lewis, 1961) such as anticholinergic toxicity (Assad, 1990)

<table>
<thead>
<tr>
<th>Alcohol Withdrawal Signs</th>
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<tbody>
<tr>
<td>• Rapid pulse</td>
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<tr>
<td>• Sweating</td>
</tr>
<tr>
<td>• Hand tremors (&quot;shakes&quot;)</td>
</tr>
<tr>
<td>• Anxiety</td>
</tr>
<tr>
<td>• Irritability</td>
</tr>
<tr>
<td>• Hallucinations</td>
</tr>
<tr>
<td>• Mental confusion</td>
</tr>
<tr>
<td>• Seizures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BAC &amp; Physiologic Effects³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BAC – mg/dL</strong></td>
</tr>
<tr>
<td>20-50</td>
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<tr>
<td>50-100</td>
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<tr>
<td>100-150</td>
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<tr>
<td>150-250</td>
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<tr>
<td>300</td>
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<tr>
<td>400</td>
</tr>
</tbody>
</table>

• **Marijuana** - The most widespread and frequently used illicit drug. It is associated with the following consequences:

♦ Short-term memory loss
♦ Accelerated heartbeat
♦ Increased blood pressure
♦ Difficulty with concentrating and information processing
♦ Lapses in judgment
♦ Problems with perception and motor skills
♦ Chronic, long-term marijuana use can lead to a loss of ambition and an inability to carry out long-term plans or to function effectively.

• The astute psychiatrist will always ask the marijuana user if he or she “laces” or sprinkles the MJ with other substances. Common substances used to lace MJ include: cocaine (“primo”), PCP, formaldehyde/embalming fluid (“wet”).

• **Stimulants** (cocaine, "crack," amphetamines) produce a temporary feeling of enhanced power and energy. Stimulant abuse can lead to serious medical problems:
  - Heart attacks—even in young people with healthy hearts
  - Seizures
  - Strokes
  - Violent, erratic, anxious, or paranoid behavior

• Recent use of cocaine, speed and other stimulants prior to incarceration commonly causes the patient to “crash,” and feel extremely depressed, increasing their risk of suicide.

• Cocaine use during pregnancy may result in miscarriages, stillbirths, or low-birth-weight babies who may be physically dependent on the drug and later may develop behavioral or learning difficulties.

• **Cocaine Withdrawal**- may develop hours to days after the person stops or cuts down on cocaine use. Cocaine withdrawal after prolonged use often results in severe depression.

  **Cocaine Withdrawal Signs**
  - Excessive tiredness or sleepiness
  - Vivid, unpleasant dreams
  - Increased appetite
  - Irritability
  - Depressed mood
  - Suicidality

• Tactile hallucinations are frequently seen in cocaine-induced psychosis (cocaine bugs), and involve sensations of cutaneous or subcutaneous irritation (Ellinwood, 1972), sometimes leading the individual to excoriate the skin with excessive scratching (Sadock & Sadock, 2003).

• Long-term amphetamine abuse can result in psychotic symptoms, such as paranoid delusions and hallucinations.
• Heavy, long-term sedative use (Valium, Ativan, Xanax) can result in withdrawal symptoms similar to alcohol. Sedative overdose can easily result in death by slowing or stopping the individual’s breathing.

• Combining sedatives with alcohol or other drugs greatly increases the likelihood of death by respiratory depression.

• Women who abuse sedatives during pregnancy may deliver babies with birth defects (for example, cleft palate) who may also be physically dependent on the drugs.

• **Heroin** is a synthetic version of **Opium**. It can be smoked, eaten, sniffed, or injected. It produces an intense—but fleeting—feeling of pleasure. Serious withdrawal symptoms begin after 4 to 6 hours.

<table>
<thead>
<tr>
<th>Opioid Withdrawal Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritability, agitation</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
</tr>
<tr>
<td>Muscle aches</td>
</tr>
<tr>
<td>Excessive tear production</td>
</tr>
<tr>
<td>Runny nose</td>
</tr>
<tr>
<td>Yawning</td>
</tr>
<tr>
<td>Pupil dilation</td>
</tr>
<tr>
<td>Goose bumps</td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Sweating</td>
</tr>
<tr>
<td>Fever</td>
</tr>
<tr>
<td>Insomnia</td>
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</tbody>
</table>

• Heroin use with unclean syringes is currently a leading cause of HIV and Hepatitis.

• Drug use with unclean syringes can also result in serious infections of the heart, lungs and brain.

• Heroin use during pregnancy may result in miscarriages, stillbirths, or premature deliveries of babies born physically dependent on the drug.
• **Oxycontin, Vicodin** and other prescription narcotics are also considered opioids. They are addictive and can produce the same withdrawal symptoms. They are often obtained legally or illegally in the community and abused as street drugs.

• An overdose of heroin or other opioids can easily result in death by slowing or stopping the individual’s breathing.

• Accidental overdoses with heroin are not uncommon due to uncertainty about the strength of the heroin, intoxication and other factors. On the street, an accidental overdose of heroin is referred to as a “hot shot.”

• **Hallucinogens** are drugs such as *LSD* ("acid"), PCP ("angel dust") or the new "designer" drugs (for example, "ecstasy") that are taken orally and cause hallucinations and feelings of euphoria. Dangers from LSD include stressful "flashbacks"—reexperiencing the hallucinations. PCP can cause severe confusion, agitation and aggressive behavior.

• Excessive use of ecstasy, combined with strenuous physical activity, can lead to death from dehydration or an exceptionally high fever.

• **Inhalants** are breathable chemicals—for example, glue, paint thinner, or lighter fluid. They are commonly abused by teenagers because they are easy to obtain. They produce mind-altering effects when sniffed - called “huffing.”

• Inhaled chemicals reach the lungs and bloodstream very quickly and can be deadly. High concentrations of inhalant fumes can cause heart failure or suffocation. Long-term abuse of inhalants causes permanent brain damage.

• Substance use disorders commonly occur in addition to other psychiatric disorders, such as depression, anxiety and bipolar disorder. Both disorders must be adequately treated to achieve a successful outcome.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Duration detectable</th>
<th>False positive?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>2-3 days</td>
<td>Pseudoephedrine, phenylephrine, selegiline, bupropion, trazodone, amantadine, ranitidine</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2-3 days; Heavy use – up to 8 days</td>
<td>Topical anesthetics with cocaine metabolites</td>
</tr>
<tr>
<td>Marijuana</td>
<td>1-7 days; Heavy use – up to 1 mo.</td>
<td>Ibuprofen, naproxyn, hemp seed oil</td>
</tr>
<tr>
<td>PCP</td>
<td>7-14 days</td>
<td>Ketamine (&quot;special K&quot;), dextromethorphan</td>
</tr>
</tbody>
</table>

**Suicide Risk Assessment**

- It is important to be skillful, precise, yet empathic in your approach to asking a patient about suicide.

- A suicide risk assessment consists of:
  - Clinical evaluation
  - Identifying risk enhancing factors
  - Identifying risk reducing factors
  - Synthesizing all of the above
  - Employing clinical judgment
  - Crafting a Risk Reduction Plan

- **Dynamic risk factors** are those that can change, and therefore can potentially be targeted with interventions. **Static risk factors** do not change (e.g., gender, past attempts)

<table>
<thead>
<tr>
<th>Risk Enhancing Factors that <em>do not change</em>:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Past suicide attempts</td>
</tr>
<tr>
<td>✗ Family history of suicide</td>
</tr>
<tr>
<td>✗ Chronic physical illness</td>
</tr>
<tr>
<td>✗ Male gender</td>
</tr>
<tr>
<td>✗ Conviction of a violent offense</td>
</tr>
<tr>
<td>✗ History of childhood abuse</td>
</tr>
<tr>
<td>✗ Lengthy sentence</td>
</tr>
<tr>
<td>✗ Single or divorced status</td>
</tr>
<tr>
<td>✗ Recent past inpatient psychiatric treatment (esp. &lt; 3 to 6 months after discharge)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Enhancing Factors that <em>can be changed</em>:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Depression</td>
</tr>
<tr>
<td>✗ Suicidal ideas, plans or intention</td>
</tr>
<tr>
<td>✗ Available methods for suicide – guns, lethal medications, access to open balcony, etc.</td>
</tr>
<tr>
<td>✗ Hopelessness</td>
</tr>
<tr>
<td>✗ Irritability, anger, rage</td>
</tr>
</tbody>
</table>
Psychosis
Impulsivity
Severe anxiety and/or panic symptoms
Severe agitation
Recent substance use – alcohol, cocaine, heroin, prescription medications, etc.
Unemployment

Risk Enhancing Factors that *can happen any time*:

- Life crisis – divorce, separation, loss of child custody
- Humiliation – loss of face, rape, bullying, intimidation, assault
- Chronic pain or physical illness

Risk Enhancing Factors that are *extremely concerning*:

- Severe anxiety & rumination – agitated depression
- Acts of anticipation (tying up loose ends, wills)
- Global insomnia
- Suicidal plan
- Access to suicidal means
- Psychosis with delusions of poverty or doom
- Recent alcohol use

Risk Reducing Factors:

- Willingness to accept help or treatment
- Future-oriented plans and goals
- Hopefulness
- Good social support
- Absence of suicidal ideas or intention
- Stable mood
- Low severity of mental illness symptoms
- Religious prohibitions
- Moral objections to suicide

- Sample: **Suicide Risk Reduction Plan**

<table>
<thead>
<tr>
<th>DYNAMIC Risk Factors</th>
<th>Management Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>(subject to change)</td>
<td>(discussed with patient)</td>
</tr>
</tbody>
</table>
1. Depression - moderate
2. Gun in home
3. Alcohol abuse
4. Life crisis – marital problems

| 1. Psychiatric follow up, Cymbalta, psychotherapy referral |
| 2. Sister to accompany patient home and remove all firearms |
| 3. AA, refrain from alcohol use |
| 4. Referral to marital therapy |

**Suicide Risk Assessment In Bipolar Disorder**

**Risk Enhancing Factors**

- Past suicide attempts (past attempts: risk ↑ 4X)
- Hopelessness
- Depressive phase
- Family history of suicide acts
- Comorbid Borderline Personality
- Subjective pessimism (depression, suicidal ideas)
- Aggressive traits, hostility
- Impulsivity
- Male gender

**Risk Reducing Factors**

- Receiving effective treatment with Lithium
- Stable mood
- Hopefulness
- Future-oriented thinking
- Social support

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* Intended to supplement general suicide risk factors

5 Marangell LB, et al. Prospective predictors of suicide and suicide attempts in 1,556 patients with bipolar disorders followed for up to 2 years. Bipolar Disorders 2006; 8: 566-575


10 Decreased risk of suicides and attempts during long-term lithium treatment: a meta-analytic review. Bipolar Disorders 2006; 8: 625-639
• Willingness to accept help and/or treatment
• Good therapeutic alliance
• Religious prohibition
• Female gender
• Employed

Techniques for Improving Interviews

Interviewing Validity Techniques\textsuperscript{11}:
1. Behavioral Incident
2. Shame Attenuation
3. Gentle Assumption
4. Symptom Amplification
5. Denial of the Specific

Behavioral Incident
• “Exactly how many pills did you take?”
• “After you grabbed the knife, what did you do then?”
• (Avoid asking about opinions and/or impressions at this time)

Shame Attenuation
• Correct: “Do you find that other men tend to pick fights with you, when you are just trying to enjoy yourself at the bar?”
• Incorrect: “Do you have a bad temper and tend to pick fights?”
• (Elicit more valid data via rationalization of guilt, shame)

Gentle Assumption
• Correct: “What other ways have you thought of killing yourself?”
• Incorrect: “Have you thought of any other ways of killing yourself?”
• (Assumes behavior has already occurred)

Symptom Amplification
• “How many fights have you been in as an adult, 30? 40? 50?”
• “How many times have you attempted suicide, 10, 20?”
• (Reduces tendency to downplay the frequency of disturbing behaviors)

Denial of the Specific
• After the patient has denied a “gentle assumption,” ask series of specifics.
  Doctor: “What other ways have you thought of killing yourself?”
  Patient: “None.”

- Doctor: “Have you ever thought about overdosing?”
- Patient: “Oh, yeah. I forgot... I did think about doing that a while back.”

- Doctor: “What other street drugs have you tried?”
  Patient: “None.”
- Doctor: “Have you ever tried ‘ex’?”
  Patient: “Oh, yeah I used to do a little at this nightclub, but I quit recently. I didn’t really think that counted.”

“CASE” Approach for assessing Suicide and/or Violent Events
(Chronological Assessment of Suicide Events)

1. Presenting Event (eg., suicide attempt, homicide)
   a) Trigger
   b) Plan (lethality, notes)
   c) Actions taken on plan (stored up pills, purchased firearm)
   d) Presence of: substance use, impulsivity
   e) Degree of hopelessness
   f) What stopped event, if anything? How found
   g) Attitude & behavior after found

2. Recent Events (eg., last 6-8 weeks)
   a) Elicit using above validity techniques
   b) Uncover all events/methods using gentle assumption, denial of specific
   c) Explore each event and actions taken using behavioral incidents
   d) Assess overall frequency, duration, intensity

3. Past Events
   a) Most serious attempt (review method, lethality, similarity to presenting event)
   b) Most recent attempt (“” “” “”)
   c) Tally number of attempts

4. Immediate Events (return to here & now)
   a) Current mental status, attitudes & behaviors (hope, mood, agitation, etc.)
   b) Current intentions
Violence Risk Assessment

Historical Risk Factors
- Past violence – pattern, ego-syntonic, affective, predatory
- Severe or frequent past violence
- Use of weapons during violent acts
- Age – late teens, early 20’s
- Male
- Low I.Q
- Unemployed
- Major Mental illness
- Criminal record
- Military or combat training
- Juvenile delinquency – 1st arrest < 18
- Cruelty to animals, fire setting
- Childhood abuse
- Access to weapons – familiarity
- Recent movement of a weapon

Clinical Risk Factors
- Homicidal or violent thoughts
- Substance use
- Impulsivity
- Poor insight
- Noncompliance with treatment
- Psychosis
- Command hallucinations – Familiar voices, Hallucination-related delusions
- Delusions – Persecutory, systematized, Threat/Control-override, History of acting on delusions
- Depression – with suicidal ideas, homicide/suicide
- Mania
- Organic Brain Dysfunction
  - Traumatic brain injury
  - Frontal lobe syndrome
  - Intermittent explosive disorder
  - Temporal lobe epilepsy
  - Dementia
  - General medical condition

- PTSD
- Lack of empathy or psychopathic traits
• Antisocial or Paranoid Personality

**Acute Risk Factors**
• Homicidal or suicidal intent
• Intoxication or recent substance use
• Escalation in frequency or severity of violence
• Hostage taking
• Threats to kill
• Threats to harm the children
• Actions taken on plans/threats
• Unconcerned with consequences
• No alternatives to violence seen

**“SIG E CAPS”**
- Sadness – all day, nearly every day for 2 weeks
- Insomnia – or hypersomnia
- Guilt – excessive, inappropriate, feelings of worthlessness
- Energy level decreased
- Concentration impaired – difficulty making decisions
- Anhedonia
- Psychomotor changes – retardation or agitation
- Suicidal or morbid ideation
"SPEED UP"
- Sleep decreased
- Pressured speech
- Euphoria or irritability
- Elevated self-esteem (grandiosity)
- Distractability
- Unrestrained, goal-directed activity
- Psychomotor agitation

**Drug-induced EPS**

1. Dystonia – 90% in 1st 4.5 days
2. Parkinsonism – 90% in 1st 72 days
3. Akathisia – 90% in 1st 73 days
4. TD – 25% after > 4 years

**Acute Dystonia**
- Torticollis, retrocollis
- Oculogyric crisis
- Jaw spasms, tongue protrusion
- Impaired swallowing, breathing, speaking
- Risk: early, high potency, young male
- Emergently administer Benadryl or Cogentin

**Akathisia**
1. Lower dose or change the antipsychotic or SSRI
2. Consider propranolol 10mg tid if cannot do above
3. Consider ativan short-term to reduce severe discomfort

**Parkinsonism**
(TrAP)

1. **Tremor** at rest (3-6 hz)
2. **Rigidity** – cogwheel or lead pipe
3. **Akinesia/Bradykinesia** – movement, mask-like face
   **Postural instability**

**Tardive Dyskinesia Risk Factors**
- Long-term antipsychotics
- Elderly
- Female
- Mood disorder
- Cognitive disorder
- Pre-existing basal ganglia lesions

**Neuroleptic Malignant Syndrome**
(RAD)

1. **Rigidity**
2. **Autonomic instability** (fever, HR)
3. **Delirium**

Labs = elevated WBC & CPK
♀ 20% mortality ♂
Emergent administration of Dantrolene and/or Bromocriptine

**NMS Risk Factors**
- Pre-existing basal ganglia lesions
- High doses of antipsychotics
- Rapid dose titration
- Multiple antipsychotics (polypharmacy)
- Depot injections
- Adjunct Lithium
- Dehydration ♂
- Heat exposure ♂
Does the patient need Crisis Intervention?

Crisis Intervention Steps:

1. Determine the Problem – e.g., Loss of: Love? (spouse, family) Work?
2. Assess the Person’s Perception of the Problem
3. Explore Alternatives for Solving the Problem or Reducing the Stress
4. Allow Person to Choose or Accept a Plan for Resolution
5. Summarize the Interaction with Person

What is the best disposition for the patient?

- If you do not document your reasoning, there will be no evidence to show that you were thoughtful, and did use reasonable professional judgment.

- The options most often consist of:
  - Inpatient hospitalization – involuntary
  - Inpatient hospitalization – voluntary
  - Intensive outpatient treatment or “Partial Hospitalization”
  - Outpatient psychiatric treatment and/or psychotherapy

- It is recommended that you document your reasons for considering a particular disposition, as well as why you opted not to use an alternative.

Documentation
• The importance of good documentation cannot be overstated. It is the central piece of evidence in every malpractice trial.

• Good documentation has stopped many malpractice cases from proceeding.

• Courts do not expect you predict the future or never make any errors. They do expect you to use “reasonable professional judgment” based on a thorough consideration of the factual/clinical data.

• If you do not document your reasoning, there will be no evidence to show that you were thoughtful, and did use reasonable professional judgment.

• When documenting – use the rule of austerity. Document the important facts and conclusions in an objective tone. Never let your emotions bleed onto the paper – this will only hurt you.